STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SU	URVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DULL DING 01 COM		COMPLE	COMPLETED	
		155224	A. BUILDING	09/19/		11	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			ı				
COLLIME		CENTED		'EST COLUMBIA STREET SVILLE, IN47710			
COLUME	BIA HEALTHCARE (JENIER	EVAIN	SVILLE, IN477 IU			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
K0000							
	A Life Safety Co	ode Recertification	K0000				
	and State Licen	sure Survey was					
	conducted by t	he Indiana State		Kim Rhoades Indiana Stata Danartment of H	oolth		
	Department of			Indiana State Department of Health 2 North Meridian Street			
	-	h 42 CFR 483.70(a).		Indianapolis, IN 46204			
	accordance wit	11 42 CIR 463.70(a).		manuapons, 11 · 1020 ·			
				Dear Kim Rhoades,			
	Survey Date: 0	9/19/11					
				Please accept this 2567 Plan of	Please accept this 2567 Plan of		
	Facility Numbe	r: 000129		Correction for the Annual Life	- 1		
	Provider Numb	er: 155224		Survey ending 9/19/2011 as ou	ır		
	AIM Number:	100266780		Letter of Credible Allegation.			
				Facility respectfully requests a Post			
				Survey review on or after Octo	ber		
	Surveyor: Lex Brashear, Life Safety			12, 2011.			
	Code Specialist						
	At this Life Safe	ety Code survey,		Thank you for your time in rev	iewing		
	Columbia Healthcare Center was			our plan of correction and plea			
	found not in compliance with			with any questions.			
		for Participation in					
	Medicare/Medicaid, 42 CFR						
	· · · · · · · · · · · · · · · · · · ·			Sincerely,			
	Subpart 483.70(a), Life Safety						
	from Fire and the 2000 edition of						
	the National Fire Protection			Matthew Trammell, HFA			
	Association (NFPA) 101, Life Safety			Executive Director			
	Code (LSC), Ch	apter 19, Existing		Executive Birector			
	Health Care Oc	cupancies and 410					
	IAC 16.2.	•					
	This true stam facility with a						
	This two story facility with a basement was determined to be of						
	Type II (111) co	onstruction and was					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K2X821

Facility ID:

000129

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155224		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV. A. BUILDING 01 COMPLETED 09/19/2011		ETED				
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 621 WEST COLUMBIA STREET EVANSVILLE, IN47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
K0050 SS=F	a fire alarm syst detection in the open to the corresident rooms 2400 halls. The capacity of 186 of 121 at the till Quality Review by I Code Specialist-Med The facility was compliance with aforementioned requirements a following: Fire drills are held varying conditions shift. The staff is fis aware that drills routine. Responsi conducting drills is competent person exercise leadershic conducted between announcement manualible alarms. Based on recordinterview, the fiprovide quarter 3 shifts during	in the 1400 and e facility has a and had a census me of this survey. Robert Booher, Life Safety dical Surveyor on 09/20/11. I found not in the d regulatory s evidenced by the at unexpected times under at least quarterly on each amiliar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 d review and acility failed to rly fire drills for 1 of 1 of 4 quarters. bractice could affect	K0050		K050 It is the policy of this fact that fire drills are held at unexpected times under varying conditions, at least quarterly of each shift.	ıg	10/12/2011	

000129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155224 09/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 621 WEST COLUMBIA STREET COLUMBIA HEALTHCARE CENTER EVANSVILLE, IN47710 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE What corrective action(s) will be Findings include: accomplished for those residents found to have been affected by the Based on review of the facility's deficient practice fire drills in the Life Safety Reports Training conducted with book on 09/19/11 at 10:45 a.m. Maintenance supervisor with the Maintenance Supervisor completed. Education included but present, the facility lacked written not limited to: Frequency of fire drills, documentation of fire drills, documentation to show a fire drill and tracking of the drills. was conducted during the third (night) shift of the second quarter (April, May, and June) of 2011. How will you identify other residents having the potential to be This was acknowledged by the affected by the same deficient Maintenance Supervisor at the practice and what corrective time of record review. action will be taken 3.1-19(b)This alleged deficient practice could affect all residents in the facility. **Training with Maintenance** personnel over policy and procedure of fire drills. What measures will be put into place or what systemic changes vou will make to ensure that the deficient practice does not recur All fire drills will be conducted and results submitted to Health **Facility Administrator upon** completion.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE S	B) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED	
		155224	A. BUILDING		09/19/2	011	
			B. WINC	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ST COLUMBIA STREET		
COLLIMB	BIA HEALTHCARE (^ENTED					
	DIATIEALITICANE (SENTER	EVANSVILLE, IN47710				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL]	PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					How the corrective action(s) w	vill	
					be monitored to ensure the		
					deficient practice will not recur, i.e., what quality assurance program will be put into place		
					program win be put into place	,	
					· Fire Drill audit tool will	be	
					utilized weekly x4, monthly x 2	2 and	
					quarterly thereafter.		
					· The CQI committee will		
					review the audits and action pla		
					will be developed, as needed, to		
					improve compliance. Noncomp with facility policy and procedu		
					may result in employee education		
					and/or disciplinary action up to		
					including termination.		
					S		
					Compliance date: 10/12/2011		
K0062	•	ic sprinkler systems are					
SS=E	•	tained in reliable operating inspected and tested					
		.7.6, 4.6.12, NFPA 13, NFPA					
	25, 9.7.5	,,,,					
	Based on obser	rvation and	K0	062	K 062 Life Safety Code Standa	ard	10/12/2011
	interview, the f	acility failed to			It is the policy of this facility to		
	ensure 2 of ove	er 1000 sprinkler			ensure required automatic	·	
	heads in the fa	cility were free of			sprinkler systems are continuo	ously	
	corrosion. NFF	PA 101 Section 9.7.5			maintained in reliable operation	ng	
	refers to NFPA 25, Standard for the Inspection, Testing, and				condition and are inspected and tested periodically.		
		f Water-Based Fire					
	Protection Syst	ems. NFPA 25,					
	2–2.1.1 requires sprinklers to be						
	•	Any sprinkler shall			What corrective action(s) will		
	paint. 7				accomplished for those resider	nts	

000129

				(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING 01		COMPLETED	
155224		B. WIN	G		09/19/2011		
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF TROVIDER OR SUITEER				1	EST COLUMBIA STREET		
COLUME	BIA HEALTHCARE (CENTER		EVANS	VILLE, IN47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
	be replaced tha	=			found to have been affected by deficient practice	y the	
		deficient practice			dencient practice		
	could affect mo	ostly staff while			No residents were affected.		
	working in the	Laundry Room.					
	Findings include:				How will you identify other residents having the potential affected by the same deficient	I	
	Based on obser	vation on			practice and what corrective		
	09/19/11 at 1	1:25 a.m. during a			action will be taken		
	tour of the facility with the Maintenance Supervisor, two sprinkler heads in the washer area of the Laundry Room were covered with corrosion. This was acknowledged by the Maintenance Supervisor at the time of						
					No resident has potential of being affected.	ing	
					The identified two sprinkler he	eads	
					y		
					standards.		
					W714		
	observation.	ie time or			What measures will be put in place or what systemic change		
	observation.				you will make to ensure that t	I	
	2 1 10/b)				deficient practice does not rec		
	3.1–19(b)				Training conducted with		
					maintenance personnel to incl	lude	
					sprinkler head maintenace.		
					How the convertible of		
					How the corrective action(s) v be monitored to ensure the	VIII	
					deficient practice will not reco	ır,	
					i.e., what quality assurance		
					program will be put into place	e	
					· The sprinkler head audi will be utilized bi-monthly x2,		
					monthly x 3 and quarterly there	I	
					· The CQI committee wil	1	

000129

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 09/19/2011			
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 621 WEST COLUMBIA STREET EVANSVILLE, IN47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)				
				review the audits and action particle. Will be developed, as needed improve compliance. Noncompliance with facility policy and process may result in employee educated and/or disciplinary action up including termination.	to npliance dure ation			
				Compliance date: 10/12/201	1			